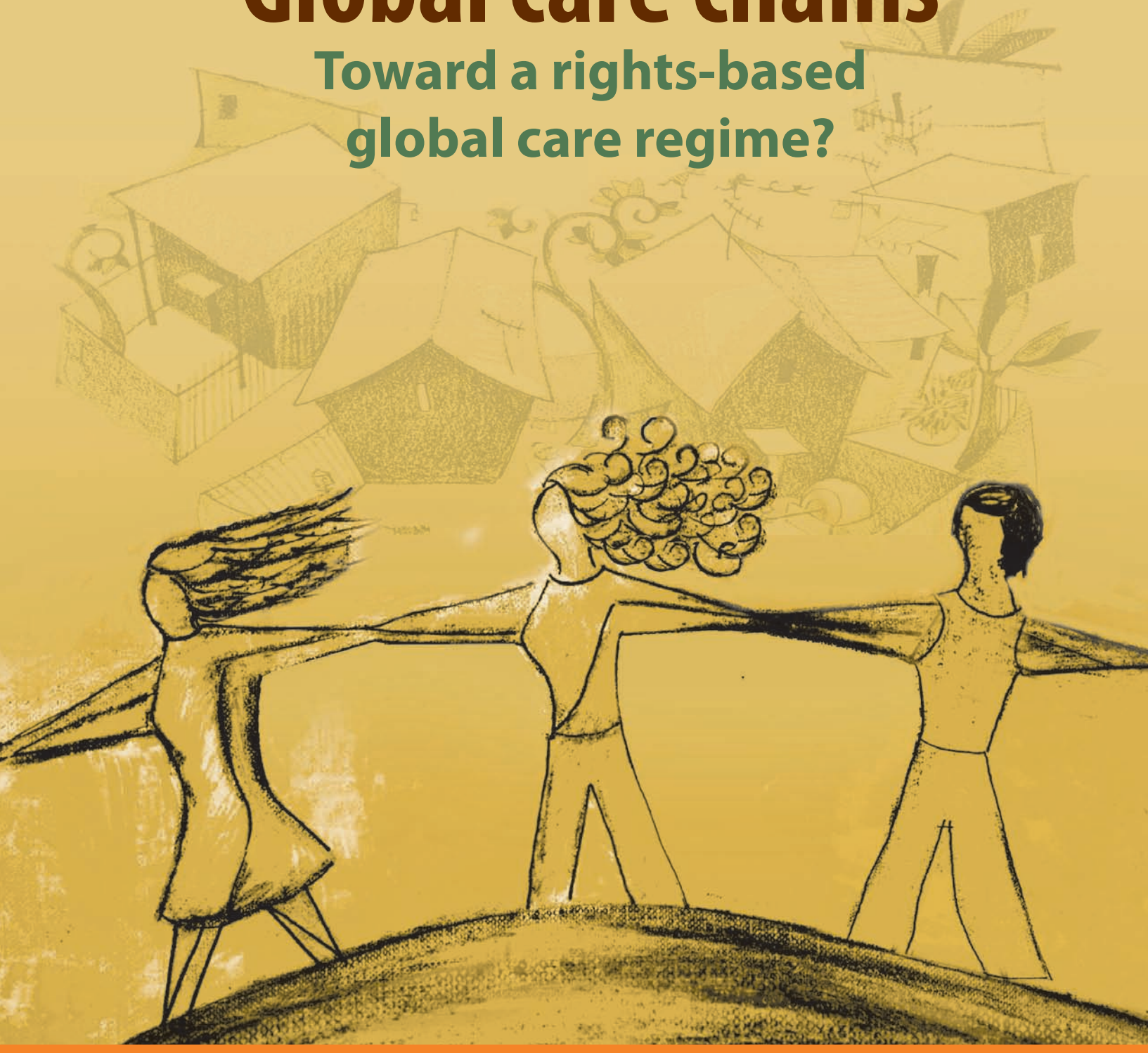
# Global care chains

## Toward a rights-based global care regime?



united nations instraw Part of UN WOMEN

MINISTERIO DE ASUNTOS EXTERIORES Y DE COORDINACIÓN
SECRETARÍA DE ESTADO DE COOPERACIÓN INTERNACIONAL
DIRECCIÓN GENERAL DE PLANIFICACIÓN Y EVALUACIÓN DE POLITICA PARA EL DESARROLLO

aecid

# Global care chains

## Toward a rights-based global care regime?

Amaia Orozco

united nations instraw Part of UN WOMEN

MINISTERIO DE ASUNTOS EXTERIORES Y DE COOPERACIÓN
SECRETARÍA DE ESTADO DE COOPERACIÓN INTERNACIONAL
DIRECCIÓN GENERAL DE PLANIFICACIÓN Y EVALUACIÓN DE POLITICA PARA EL DESARROLLO

aecid

**The United Nations International Research and Training Institute for the Advancement of Women (UN-INSTRAW - part of UN WOMEN)** promotes applied research on gender issues, facilitates knowledge management, and supports capacity-building through networking mechanisms and multi-stakeholder partnerships with UN agencies, governments, academia and civil society.

Global care chains. Toward a rights-based global care regime?
Author: Amaia Pérez Orozco
Translation from Spanish: Laura Olsen and Michele Bantz
Lay out: Sughey Abreu

United Nations International Research and Training
Institute for the Advancement of Women (INSTRAW)
César Nicolás Penson 102-A
Santo Domingo, Dominican Republic
Phone: 1-809-685-2111
Fax: 1-809-685-2117
Email: info@un-instraw.org
Webpage: http://www.un-instraw.org



ISBN: 978-92-1-127069-3
eISBN: 978-92-1-054576-1

This document is the result of UN-INSTRAW's research into migration, gender and development, and the organization's recently launched work in a new strategic area: global care chains.[1] UN-INSTRAW is convinced that the formation of global care chains embodies the broader process of the globalization of care and provides a valuable position from which to examine the interrelationship between migration and development.

The study of global care chains most often considers Asian migration (within Asia, or interregional migration in the case of migration to the United States) and rarely at migration from Latin America and the Caribbean. That is the focus of this paper, where we ask both "what is happening" and "how to intervene". Our intention in bringing this paper to the public debate is threefold: 1) to show the importance of including caregiving in discussions around development; 2) to argue that we cannot address caregiving without considering globalization and migration; and 3) to raise new elements of reflection for those already working in the area of the social organization of care, such as the issue of development from a transnational perspective.

1 This work builds upon other topics covered in INSTRAW migration research, which previously focused on the use and impact of remittances. It also derives from conceptual reflections and results of earlier empirical work (see UN-INSTRAW's 2005 conceptual framework, updated in 2008). This broadening of focus is also physical, since UN-INSTRAW now has an office at the Autonomous University of Madrid (Universidad Autónoma de Madrid), Spain.

# Principal ideas of the document

## Care is the invisible base of the socio-economic system

- It is understood that care is the responsibility of women and is, for the most part, performed without monetary compensation.

- Because care work is neither paid nor valued, it is not measured; because it is not visible, it is not taken into account in policymaking. Time-use surveys are a key tool to end this vicious cycle.

- Unpaid care work often acts as a cushion that absorbs the costs of readjustments in the economic system. Care's invisibility means that it enters the public debate only when care needs are not being met.

## The link between care, inequality and exclusion: A non-debate

- The long-standing connection between care, social inequality and exclusion from citizenship, which is today taking on new and serious global dimensions, urgently needs to be recognized and addressed.

    - This link is an integral part of care regimes. While it has been systematically tied to gender-based and socio-economic inequalities in the past, it is currently associated with migratory status.
    - The absence of a sense of social responsibility regarding care, coupled with the relegation of care to households (and subsequently to women), means that the opportunity to receive care serves in itself as an indicator and vector of social inequality.
    - An economistic perspective cannot be used to understand care: the market-based provision of care fails to follow the simple rules of supply and demand, and money is not the only aspect that must be examined. The availability of social networks is a key factor.
    - Care is not socially or economically valued, thus the burden of caregiving falls upon those who have decreased ability to make their own choices and decisions. Here lies the root of the segmentation by sex, ethnicity and migratory status seen in this type of work.

- A non-debate: care regimes are formed on the basis of exclusion and inequality, on the sidelines of public debate.

- Care is part of the hidden development agenda as a result of its role in the private domestic arena.
- A democratic debate urgently needs to be initiated: who should provide care, who should receive it, how, where, and in exchange for what, are all matters that need to be discussed. These debates cannot be held if only the voices of unions and employers are considered legitimate.

## Care is already global: global care chains

- Today no aspect of the socio-economic system is so autonomous that it can be explained within the boundaries of national borders. It is essential to introduce a transnational perspective to the analysis of care demand and provision.

- As individuals move, work in the care sector is internationalized. This constitutes what are called "global care chains': the interconnection of households in different places around the world that transfer care giving tasks from one household to another.

- Migration transforms the way in which care is carried out; the resources available for caregiving; the way in which family, maternity and paternity are managed and understood; and the very concept of what it is to provide (good quality) care.

- Increasingly, supranational actors (multinational corporations, international cooperation agencies, multilateral agencies) are involved in the provision of care, and the industry is being outsourced to less expensive locations.

## Impacts of the globalization of care on development: some certainties and many questions

- The effects on development must be assessed on two levels: in the households directly involved in the care chains, and across the socio-economic structure.
  - The ambivalent and/or contradictory impacts on households need to be assessed on three levels: 1) the households of employers in destination countries: hiring additional labour for care work is not a miracle solution but a response to urgent needs; 2) transnational households: there are contradictory results between the different areas that guarantee material and emotional reproduction; 3) migrant households: these households often experience a gross violation of their care rights.
  - There is a worrying shortage of systematic analysis on care's impact on development, as care is still fundamentally perceived as a private family matter. This is made worse in the country of origin, where studies tend to use imported concepts and methodologies that do not respond to their realities.

- The serious problems associated with denial of care rights in countries of origin are not created by migration, nor does migration resolve these problems in destination countries. In both cases, however, it can reveal the existence of these problems. Is migration serving as a catalyst to demand public accountability and answers from society as a whole?

  - The social reproduction of care is now doubly privatized: the responsibility of guaranteeing care stays in the household, and care is increasingly purchased in the market.

- Care continues to be invisible and excluded from public debate. When care leaves the boundaries of the household, it does so in the form of individualized buying and selling, not as a right. Care labour is still unfairly distributed between different social groups along lines of gender, class, and ethnicity: the sexual division of labour takes on new global dimensions.

- In countries of both origin and destination, caregiving has produced changes in gender relations that bring latent problems to light. This tends to result in a process of intensified privatization of social reproduction and in a refashioning of the sexual division of labour. Might this be the old solution of avoiding public care responsibilities through an unjust distribution of labour, now with a new transnational dimension?

## Articulating care rights

- Breaking the vicious cycle between care, inequality and exclusion calls for care rights to be configured as a core component of the development process and of citizenship.

- This universal right has yet to be created and is multifaceted. It includes:

    - The right to receive the care needed according to one's requirements in different circumstances and at different times in one's life;
    - The right to choose whether or not one wants to provide care, combining a right to provide care in decent conditions with the right to not provide care;
    - The right to dignified working conditions in the care sector.

## Care as a public responsibility

- Articulating a right to care entails putting an end to the substitutory role that the government tends to play to cover shortcomings faced by households, and removing care from targeting policies. A number of measures can be implemented to articulate this right:

    - Time for care: provisions that will free up time from employment so that it may be devoted to providing unpaid care. However:

        - Unpaid provisions may accentuate women's greater labour and social vulnerability, and some may not be equally provided for men and women.
        - The relevance of this measure and how applicable it is to large-scale contexts in the informal and/or self-employed sectors is questionable, as such measures tend to pivot on formal wage-earning work.

    - Money for care: provided in consideration for caring for a member of the family. However: How should this type of pre-existing unpaid work be recognized and valued without further encouraging a situation in which most care is provided free of charge?

    - Care services: in the household or in institutionalized spaces. However:

        - Who should take charge of these services and how? Should businesses be required to provide services to their employees?

- Should the government offer these services, either by providing them directly or financing their purchase at private centres or on the free market?

- Guiding criteria for deciding which measures to implement:

  - Care should be recognized as a fundamental component of well-being and not as an instrument for other purposes. Care rights must not be anchored by a productivist argument based on investment in human capital.
  - A distinction must be made between health care, education, care and social protection, and boundaries must be defined between the professionalization of caregiving and other professional skills.
  - The interrelationship between the various facets of the multidimensional right to care may or may not assume the form of positive feedback:

    - Providing/receiving care can easily become contradictory if, for example, advantage is taken of a mother's role as an unpaid caregiver or if the sector is privatized and care work becomes a precarious form of employment.
    - Care implies interdependent social relationships; care rights cannot be enjoyed in only one of their two facets (giving or receiving), but rather in both concurrently.

## Care rights – under what economic regime?

- Under what economic regime can care rights be articulated and exercised? This question must be answered on an organizational and structural level.

- On an organizational level: how can the "care diamond" be rearticulated if we want to redistribute the burden borne by households?
  - Care services are profitable if a wide range of options are offered based on the affordability thresholds of the care-users, and if advantage is taken of precarious, vulnerable employment.
  - Guaranteeing equal access to the care needed without impinging upon labour rights requires such care to be provided by entities other than companies (such as the government or the non-profit sector).

- On a structural level, the question is therefore what logic should be followed to determine how the interplay of agents must be structured? Can socio-economic systems that pivot on the accumulation of capital take charge of ensuring care rights?

  - With care rights as a guiding principle, comprehensive social changes are needed, and aspects that constitute the very heart of socio-economic systems must be reconsidered:

    - the organization of habitable spaces;
    - the organization of time;
    - the concept of an ideal worker and typical integration into the economy: the productive-worker model is incompatible with care rights.

- The debate needs to be urgently redirected toward this structural level, and care rights must not be viewed as a clean-cut decision based on the most efficient or equitable measures within the available range of options.

## A final consideration: For a fair global care regime

- Care is a key element in differentiating between social groups:
  - It must be part of redistribution policies.
  - Privileged social groups have access to dignified care; other groups can only access precarious care services.

- In focusing on the right to care, we must avoid inheriting the issues related to liberal and/or ethnocentric feminism:
  - The contrast between formal recognition and practical execution: how can we ensure that this right does not remain in rhetorical limbo?
  - The liberal and individualized character of rights claims: how can we ensure that the demand for care is based on mutual commitment and collective organization, and that the interdependence of care itself is renegotiated?

- Placing care at the center assumes that development will be ethically and morally redefined.

- Towards a fair global care regime: based on social rules of conduct, decent care should be an immediate and inalienable right, and just care should be a required outcome.

# Table of contents

# 1. Introduction[2]

We are living in a multifaceted global crisis in which the financial crisis has meant the collapse of the current development model. Various crises have impacted social and economic structures: the food crisis, the environmental crisis, the energy crisis and… the care crisis.

Before the outbreak of the financial crisis, the care crisis (or crises[3]) was already being felt in countries both at the centre and the periphery. In the former, the crisis consists of a breakdown of the previous model of providing care based on the Fordist nuclear family model and the classic sexual division of labour, in which care was treated as the cost-free responsibility of women in the private, domestic sphere. As expectations of social reproduction change, a redistribution of work becomes necessary that, if it were not to take place, would create strong social and family tensions. In peripheral countries, the crisis refers more to the difficulties of guaranteeing social reproduction processes themselves, which lead households to deploy new survival strategies. These strategies are also cross-cut by the different responsibilities assumed by women and men, involving different costs and responses from different actors. In order to comprehend the multidimensional global crisis, an initial, essential task is to consider care as inherent to the crisis itself.

This paper begins by recognizing care as the invisible basis of any socio-economic system (section 2), and sets out that, despite the diversity of care regimes, a systematic connection can be observed between care, inequality and exclusion (section 3). The organization of care is not unchanging, and in fact, today, we can say that it is being globalized and manifested in what are known as "global care chains" (section 4). What are the development implications of the globalization of care? The serious problems associated with denial of care rights in countries of origin are not created by migration, nor does migration resolve these problems in destination countries. In both cases, however, it can reveal the existence of these issues. However, migration is not serving as a catalyst to demand public accountability and answers from society as a whole; rather, it is leading to an intensified privatization process of social reproduction (section 5). Breaking the vicious cycle between care, inequality and exclusion that is currently reproduced on a global level, calls for care rights to be configured as a core component of the development process and of citizenship. How are we to understand this universal, multifaceted right that is yet to be created, and via which public policies should be it be implemented? (section 6). We cannot claim care rights as a clean-cut decision based on the most efficient or equitable measures within the available range of options, but instead it has become urgent to take the debate to the structural level: Within what economic regime can the right to care be articulated and exercised? Can socio-economic systems that pivot on the accumulation of capital take charge of ensuring care rights? (section 7). And one final consideration: how can a global care regime be an inalienable dimension of the good life? (section 8).

---

2. This document is a result of UN-INSTRAW's work in the area of migration, gender and development, and its recent undertaking of a new strategic field: global care chains (see www.un-instraw.org). It is fed by the reflections and discussions held as part of the Project financed by the Spanish Agency for International Development Cooperation (AECID), "Creating networks: Latin American women in global care chains". These discussion have been maintained with our colleagues from all the participating teams (from the following institutions: CIDES-UMSA in Bolivia, Cesnter for Women's Studies (Centro de Estudios de la Mujer) in Chile, FLACSO in Ecuador, and CISEPA-Pontifical Catholic University (CISEPA-Pontificia Universidad Católica) in Peru). Although each of our colleagues (all women, with the occasional man) has not been referenced in this document – with the exception of concrete data or quotations – we wish to acknowledge that without their participation in shared reflections and ongoing conversations, this document would never have been shaped as it has been.

3. Zimmerman et al. (2006) speak of "multiple crises of care", including lack of care, the commodification of care, and the growing role of supranational organizations in the provision of care in so-called developing countries.

# 2. Care as the invisible base of the socio-economic system

The functioning of markets, the future of political structures, the creation of culture and thought… all that we normally assess in order to speak about development has a sine qua non condition: the daily production and reproduction of a population's life and health – the care of everyone in a society.[4] It can therefore be said that caregiving and reproductive labour are the base on which the entire socio-economic system is built. Who is in charge of care? How is care performed? How is care compensated? The answer is not simple, but we can identify at least two characteristics: **the responsibility of care is understood as women's work[5] and most often care is performed without monetary compensation.** In our capitalist society all activity that does not involve monetary flow becomes invisible, and is neither seen nor valued. Although the (in)visibility of socio-economic processes is multidimensional, that lack of data is an essential aspect that makes the problem more acute: because care work is not valued, it is not measured; because it is not visible, it is not taken into account in policymaking.

Care is the invisible base of the system. It is used free of charge as the last recourse of systematic readjustment, and only noticed when it is lacking. For years, the debates surrounding welfare states have ignored the fact that their social systems are underpinned by the provision of this invisible work – an unsurprising oversight, given the inability of systems to understand the interactions between market, government and household.[6] It is at the time of the above-mentioned crisis that the relevance of setting up the so-called fourth pillar of well-being (care of dependents) is discussed, and benefits and services designed to facilitate balance between personal, family and work life are extended. **Care, however, is a base that is implicitly taken for granted.** Thus, the implementation of adjustment policies that reduce the public sector's responsibility, de facto, assumes that there is a cushion of family work to cover what was once a public responsibility and to compensate for the lack of basic services. Similarly, the so-called New Social Policy (typical of many Latin American countries) establishes programmes of conditional cash transfer as the key component of poverty reduction strategies. In these programmes mothers receive a minimum income if they guarantee their children's access to education and health care.[7] Care is always there, sustaining the population, even if we take its existence and infinite flexibility for granted. **Unpaid care work often acts as a cushion that absorbs the costs of readjustments in the economic system. Care's invisibility means that it enters the public debate only when care needs are not being met.**

---

4. By "care", we are referring to the management and daily maintenance of life and health. For the most part, this sustenance is guaranteed daily through women's unpaid work in the home through direct care to people in situations of dependency. For this care work to be performed, certain "care preconditions" (food, cleanliness, etc.) – basic needs shared by all – must be met. The form of care and the meanings associated with it involve deep ethical feelings and life goals. That is, although care is a daily task, it conveys a "sense of transcendence "(Anderson, 2008; our translation); care is a key dimension of human development, understood as being able to live a life worth living with dignity.
5. The association of care with women works in two ways. On a symbolic level, its relationship with femininity results in an inherent disqualification of knowledge that this work requires; since it is considered "natural" for women to do, it is not considered as skilled work or as work at all. Care is "naturalized" and becomes a defining capacity of the "woman–mother", who is responsible "not only for her biological children, but for all members of society" (Andia Fagalde, 2009; our translation). On a material level, care responsibilities are adjudicated to women, either by direct execution or by their management in the case of purchasing care on the market or utilizing public services.
6. For a good analysis of Latin America that integrates these dimensions, please see Martínez Franzoni (2007).
7. On the relationship between unpaid care work and social policy in periphery countries, please see Razavi (2007a; 2007b), Molyneux (2007) and UNRISD (2009).

**Time-use surveys[8] are a vital tool used to break this vicious cycle of invisibility, undervaluing, and cost-free exploitation.** They allow the capture of the enormous amount of unpaid work that allows economic structures to function, and thereby capture an essential element to advance the understanding of caregiving (who, where, how, to whom, under what conditions, etc.) Because their use is fairly recent, the development of time-use surveys is still quite rudimentary, especially in terms of scope and methodological quality. But perhaps the principal problem is that the results provided are not interpreted together with other data to support public decision making. The richness of the data they offer is not sufficiently exploited, nor are they used to understand the system as a whole.

## Time-Use Surveys: Making visible unpaid (care) work

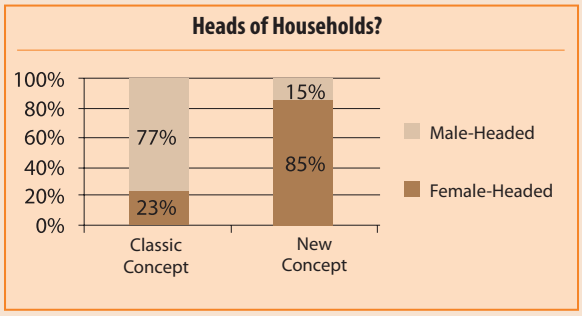
Time-use surveys allow us to answer the question of how well-being is generated and who is responsible. Notwithstanding the very diverse methodologies used by different time-use surveys, in general terms all tend to confirm the following findings:

## Finding 1: Global workload: How and by whom is well-being generated?

- Unpaid work is a central component that ensures levels of well-being and economic activity.
- Women work more hours than men, i.e. they take on more than half of the total work time that is necessary for society to function.
- Work in general, and paid work in particular, are distributed unequally between men and women. Women have a larger general workload (i.e. they work more hours), and they dedicate more than double the time of men to unpaid work.
- The distribution of unpaid work varies between countries: in peripheral countries lack of basic infrastructure and technology requires that more time be invested in activities such as collecting water, washing clothes etc., which lose importance as acquisitive power is gained.

## Finding 2: Heads of households?

Based on the data provided by time-use surveys, we are able to rethink the term "head of household". If we consider the main figure in the home as the one who assumes most of the daily tasks of maintaining the household (through care and domestic work), the majority of households are headed by women:




*Source:*
*ECLAC and Vásconez et al. (2009)*

8. Budlender (2008) has noted some methodological flaws (in survey design and in surveying process itself), but the most notable deficiencies are in the operation and subsequent use of the data. For a guide on how to implement time-use surveys, see UNSD (2005). UN-INSTRAW was a pioneer in the study of unpaid household work, one of the institution's areas of focus between 1984 and 1996. For more on time-use surveys please consult the International Association of Time Use Research (www.smu.ca/partners/iatur/iatur.htm) and the Center for Time Use Research (www.timeuse.org). For data on Latin America, see Milosavljevic and Tacla (2007).

### Finding 3: Differences not only according to sex

It is not enough to analyse time-use surveys according to sex; the data must also be considered according to other variables:

- Experiences of unpaid work vary much more among women as a group than among men as a group.
- Social class, the environment (either rural or urban), and ethnicity are determining factors that explain time-use patterns.
- In the area under study, it is especially important to cross-examine the data from time-use surveys with the migratory experience to be able to understand how the organization of households in the country of origin is reconfigured and to know the possible differences in time use between the native population and the migrant population in destination countries.
    - An example from Spain: the foreign population dedicates more time to paid work and less to matters that are not considered strictly necessary (social life, hobbies, etc.), while investing in the household and family practically the same amount of time as the Spanish population. It can be concluded that the foreign population has less freedom to choose how they spend their time (National Institute of Data and Statistics, 2003).
    - An example from Ecuador: by comparing households with and without migrants, it can be seen that: 1) in the former, men dedicate more time to care, although in most households women continue to be the primary caregivers; and 2) women aged between 46 and 65 are the majority of care providers; according to the qualitative information, grandmothers are left in charge of the sons and daughters of migrants (Vásconez et al., 2009).

# 3. The link between care, inequality and exclusion: a non-debate

A characteristic element of care is that it is resolved in each household based on each person's access to various resources. **This means that the possibility of receiving care itself serves as an indicator and vector of social inequality.** But where does this inequality come from? Care, for the most part, continues to be provided cost-free by members of the family or the community; familism[9] remains the standard model for caregiving.

**We cannot apply an economistic perspective to care in order to understand exclusion: the market provision of care fails to follow "the simple logic of supply and demand"** (Carrasco and Rodriguez, 2000: 51; our translation) **and money is not the only aspect that must be examined.** Unequal access (or exclusion of access) to care is closely tied to the availability or absence of social networks and, specifically, family networks. A lack of income often encourages the launch of social networks, as in the case of the people's kitchens run by women in Peru. Clearly, the availability of income is a key factor when discussing inequality and exclusion, as it has as much of an indirect effect (establishing what we can term preconditions for care[10]) as it does a direct effect (care purchasing power). Still, even if money is available, there is not always a market able to meet demand[11] or a desire to outsource caregiving services. This is because familism also implies an ethical or moral resistance to contracting out care. Purchasing care is also related to ethnicity. As an example, in Bolivia the data indicates (Wanderley, 2003; Jiménez Zamora, 2009) that the tasks least delegated to paid domestic workers are those related to care of minors, while they are made responsible for harder tasks like food preparation or cleaning. This "brings to bear elements of an ethnic-cultural nature, associated with the separation of manual and intellectual work […] it infers that these "indigenous, country" women have fewer cultural resources for care tasks as it is practised in the West" (Jiménez Zamora, 2009; our translation).

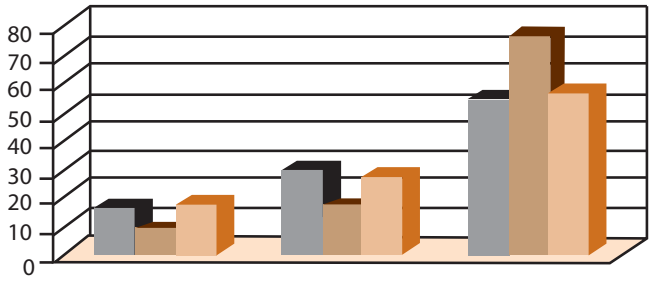
The link between care, inequality and exclusion implies **ongoing feedback between the assumption of care tasks, inequality in the distribution of work and resources, and the risk of exclusion and poverty.** Assuming responsibility for caregiving in the home not only fails to lead to rights (since rights are considered contributory benefits derived from wage-earning work) but it also seriously limits entrance into the workforce.[12] In turn, jobs in the care sector are subject to a "wage penalty" (Razavi, 2007a) and particularly precarious working conditions, which is extreme (nearing or actually in a situation of poverty) in the case of paid domestic work. The following figure shows the over-representation of homeless and poor women among domestic employees:

---

9. In its diverse forms: extended to community networks, modified by the partial commodification of care and so on.
10. For example, having a spacious dwelling is a fundamental factor in the establishment of successful personal relationships in caring for the elderly. In low-income countries, the lack of basic necessities such as a wheelchair turns individuals with disabilities into complete dependents and prevents them from enjoying autonomy in life. In addition, ensuring essential needs are met requires a tremendous amount of unpaid labour whenever access to adequate infrastructure is absent (for example, to carry water or secure fuel sources).
11. In many middle- and low-income countries, commercial services of the formal kind that provide good quality care are underdeveloped, and it is at the most informal end of the market spectrum that care is widely provided (Razavi, 2007a). In higher-income countries, the care market is little more than an emerging sector.
12. In this connection, certain concepts emerge such as women's status as a second-class citizen in the male breadwinner/female caregiver model. In this model, the wage-earning male enjoys direct rights while his wife and children, considered his dependents, enjoy derivative rights. In addition to the unbalanced assessment of wage-earning work and unpaid caregiving, this model has also been questioned because it focuses on the (patriarchal nuclear) family. This debate, however, will not be addressed in this paper. Still, it is important to point out that the right to care proposed here is understood as an individual right, not as a family right.

## Over-representation of domestic employees by poverty level

Women 15 years of age and older. Urban areas in Latin America. By poverty level and type of activity. (2005).




| | Extremely poor | Poor | Not poor |
|---|---|---|---|
| Domestic work | 16 | 29 | 54 |
| Other activity | 8 | 16 | 76 |
| Head of household | 17 | 27 | 56 |

*Source: ECLAC/ Montaño (coord.) (2007)*

**When care is not socially or economically valued, the burden of caregiving falls upon those who have fewer options and less decision-making power** (resulting from a lack of alternatives, resources, bargaining power, and so on). As Izquierdo (2008) explains, "caregiving is avoided like the plague" (our translation). Here lies the root of the segmentation by sex, ethnicity and migratory status typically seen in this job sector, and the distribution of care tasks within the family by axes of power (based on gender and age, above all).

The association between care, inequality and exclusion from citizenship is not new, but it is now taking on a new global dimension as the bond between the internationalization of care and its commodification grows stronger. This in turn strengthens the link between the quantity and quality of care received and consumption capacity, **and increases inequality according to social class worldwide.** Meanwhile, the labour niches created by this process do not significantly increase a caregiver's access to rights, because employment in the sector suffers from a distinct lack of job stability and is largely informal.[13]

### Labour discrimination and denial of the voice of domestic workers

Domestic work is a particularly precarious and vulnerable sector, as shown by the long-standing tie between work in the household and migration. This was initially between rural and urban settings, but is now international. According to ATH-ELE, the Association of Domestic Workers of Biscay (www.ath-ele.com), this type of work is and has always been "a matter for poor women" (our translation).

This type of work is often neglected in broader labour legislation and consequently lacks any form of protection (as in numerous Asian countries). In other instances, it is governed by specific regulations that contain provisions that discriminate against other sectors (as in most Latin American countries). Moreover, compliance with these regulations is often lax and, as domestic work constitutes part of the informal economy, labour inspections are seldom conducted.

13. In fact, both phenomena contribute to the feminization or domestication of this type of work, thereby prompting a transformation in both work content (for example, activities previously performed at home, such as care, are transferred to the market) and working conditions (jobs tend to replicate the conditions of domestic work). In turn, the domestication of work is intricately tied to the increase in the number of women in the labour market, a process known as the feminization of labour.

Another problem arises when regulation in the sector is discussed, as negotiations tend to be tripartite in nature between the government, unions and employers. Wage-earning domestic workers are seldom represented in unions and their own organizations thus remain sidelined in the debate.

In 1948, the International Labour Organization (ILO) declared that it would consider a specific convention on the sector. Yet over 60 years later, it has yet to begin an initial draft. During this period of time, paid work in the household has remained unprotected by international regulations. The convention is due to be approved in 2011. Given that only governments, unions and employers are able to participate in the draft process, domestic workers are coming together to have their voices heard in the reports and proposals issued by unions and governments. In this way they will attempt to participate, albeit indirectly, in the preparation of a regulation for which they are the target population.

Further information is available at www.domesticworkerrights.org.

Care regimes are formed on the basis of exclusion and inequality, on the sidelines of public debate and care is part of the hidden development agenda (UN-INSTRAW, 2008). This **non-debate** is a result of the association between care and the private domestic arena, considered irrelevant to political and socio-economic discussions. Who should provide care, to whom, how and in exchange for what, are topics that have not been publicly or politically negotiated but rather turned over to the supposed freedom of the private sphere. Still, the answers to these questions are not the result of an individual negotiation in each household but rather the interplay of ethical and moral criteria that are very closely tied to unequal gender relations and the macrosocial distribution of work (as emphasized by feminists: the personal is political). As an initial step to articulating a right to care, stakeholders must begin to openly and democratically debate what occurs in the domestic arena and acknowledge that social structures are at play within the household. The boundary between public matters and private domestic matters must also be renegotiated.

# 4. Care is already global: Global care chains

We rarely speak about care, but when we do decide to bring the issue to light, we tend to do so in a strictly limited manner, defining the discussion's scope within the territory of the nation-state. Care is one of the areas in which the negative effects of what has been called "methodological nationalism" are more strongly felt. In this understanding care is something that can be explained within national borders, without being affected by what is occurring in other spaces. In the current context of globalization it is obviously inconceivable that any element of the socio-economic system could be so autonomous. An effort must be made to reflect upon what introducing a transnational perspective to the analysis of the social demand and supply of care implies. In other words, **we need to think about how to understand the social organization of care in the context of globalization.**

The (partial and inadequate) solution to the care crisis in developed countries has been to transfer a large part of the work that was previously done cost-free by women in the household to the market place. Increasingly, this work is being performed by migrants. **Work in the care sector has been internationalized,** as much in institutionalized care work – through day care centers, nursery schools, retirement homes, domestic help services, etc., which are managed by the private or public sectors – as in households that directly hire domestic service for the family.

The provision of care is directly linked to the feminization of migration. Women are increasingly protagonists of migration, driven by the social reproduction crisis to which women respond as though they are the ultimate, if not the only, guarantor of family well-being[14] and by the work opportunities in the service sector that the care crisis has opened for them. As the International Organization for Migration (IOM, 2008) states, regardless of the migrant's level of education, female migrant labour is concentrated in occupations associated with traditional gender roles – the service sector in general, and the care sector in particular. Domestic work is the main door through which women migrants enter the workforce (and also the trap from which is it difficult to escape).

### Global care chains in evolution

Lola arrived in Spain in 2005. Her children stayed with her husband in Bolivia (constructing a transnational family). He followed a few months later (not assuming the role of primary caregiver: masculine identity is linked to the role of income provider). Both managed to work, she as a domestic worker (typical women's labour niche). Her children stayed first with their maternal grandparents, but Lola was not happy with this solution (household management from a distance) and agreed with her sister in law that she move home (reorganization of family strategies).

14. Not all migration arises from economic necessity – other factors, different for women and men, also have an impact. Among women's reasons to migrate are the desire for greater freedoms and autonomy ( in regard to sexual behaviour and life in general), escaping situations of gender-based violence, etc. See UN-INSTRAW (2008) for a more complete analysis.

When the couple achieved a certain level of job security, they wanted their children to join them before the children would need visas (family strategies affected by migration policy). The children were twice turned away at the airport. Only the oldest managed to enter (family reunification). Lola needed papers and moved with her son to another city because she had organized a contract (labour strategies affected by migration policy). She cared for an elderly woman at night and her son slept alone (difficulties balancing work and family life). Lola feels the situation is unsustainable.

In turn, the departure of women requires a reorganization of households in the country of origin and a redistribution of the care work for which these women were previously responsible. At the same time, their departure does not mean women lose contact with their families; links with the household of origin are maintained. They form what are called "transnational families", in which the management of family well-being acquires dimensions that transcend national borders. This complex process of the transfer of care and the creation of links between different households **creates global care chains.** As we have defined elsewhere, global care chains "exist transnationally, and have been established with the aim of sustaining daily life. Within them, households transfer care work from one home to another, based on power axes like gender, ethnicity, social class and place of origin" (UN-INSTRAW, 2008: 90).

### Are global care chains a "women's issue"?

- Some men who perform care labour: in countries of origin, men increase their dedication to unpaid care work, especially when staying with young children. However, this is more common in transitional situations and supported by a wide circle of women (care is dispersed). In destination countries, men are increasingly performing care work, especially for elderly men. However, a man's departure does not usually involve a significant reorganization of the household in the country of origin: a man's absence does not bring about the formation of chains. Men, neither before nor after migration, assume the responsibility of being primary caregivers and therefore do not form chains.
- Although care chains are led by women, we must consider the places that other actors, especially men, public institutions and businesses occupy, in order to identify the absence of these actors in terms of accountability and in terms of receiving the benefits of care that results from the chains.

It is not only individuals who move internationally, leading to the creation of global care chains. There are also private and public agents whose actions have supranational impacts. Put another way, supranational agents are increasingly involved in the provision of care, an aspect that deserves greater attention than it has received thus far. A significant part of care may be outsourced as the service sector is liberalized, as in the case of "telecare services" that provide telephone assistance for elderly and disabled populations. Similarly, the influence of transnational corporations may be increasing as many services are privatized (domestic help, residences, insurance agencies etc., even work in the household) and as large companies diversify the services they offer.

Besides the influence of the private sector, it is also important to note two impacts of the public sector. **On the one hand, one must consider the influence of multilateral organizations/ agencies in decision making with regards to public policies related to care or, more generally, the economic and social policies that predetermine the conditions in which they are designed.** As Zimmerman et al. note,

"How can individual societies affect positive social change and advance aspects such as improving the status of care work [...] when the policies of multilateral organizations can work against these efforts? Structural adjustment policies inhibit the advancement of women and reinforce traditional activities and roles" (2006: 24).

On the other hand, international cooperation is increasingly involved in the provision of care, either by providing care directly or by financing its supply. In addition, bilateral social security agreements that coordinate the benefits of welfare states between countries of origin and destination are also on the rise.

### Is there an automatic link between the insertion of non-immigrant women in the labour market and the importation of care work?

The migration of women and their insertion in the care sector is driven by the care crisis in destination countries which, in turn, is closely linked to the integration of non-immigrant women into the labour market. But this is not always necessarily the case.

- The care crisis does not always lead to job creation. Although Japan has experienced a care crisis, migrant women had not been contracted until recently.
- The care crisis is triggered not only by the higher rates of labour market insertion of the non-immigrant population and the aging of the population. There are other factors at play, such as the urban growth model (which significantly hinders the operation of social networks and the extended family) negates public spaces as places where care can be more collective and less intensive, makes the street a hostile place for children, increases commute time, spatially fragments the city into spaces of leisure, care and employment, etc. This pattern of urbanization is at the core of the environmental and energy crisis. The different dimensions of the global crisis feed into each other.
- The demand for foreign caregivers is not always related to the non-immigrant population's lack of time to perform care labour. There are examples, such as in the Gulf countries, where there are very high rates of recruitment of foreign domestic workers, despite the very low rates of inclusion of non-immigrant women in the labour market.

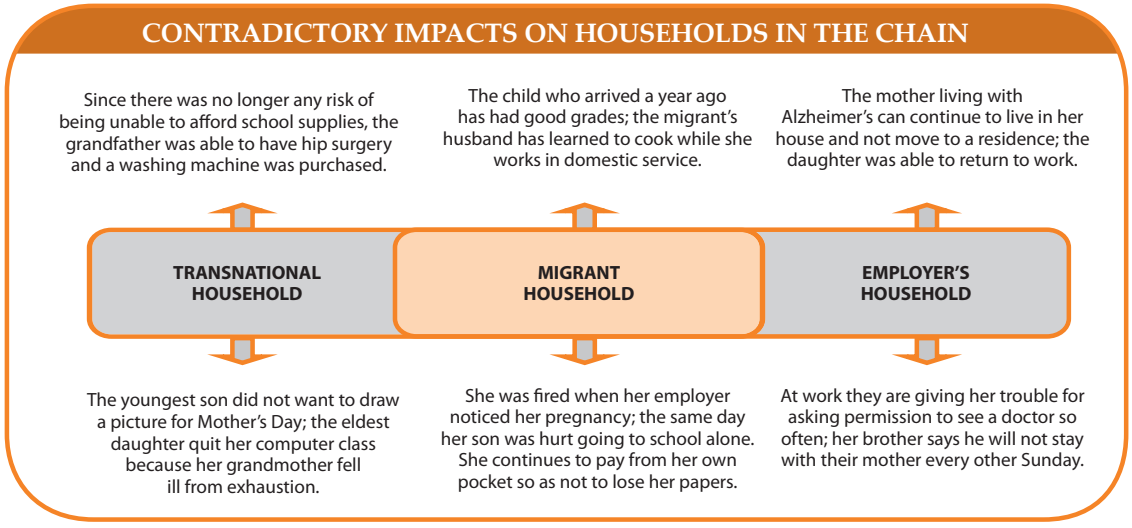
# 5. Impacts of the globalization of care on development: Some certainties and many questions

The provision of care is becoming globalized, linked as it is to the crises in countries of destination and origin and changes in gender relations. **How are these changes to be understood in terms of development?** As we have argued at UN-INSTRAW (2007b; 2008), this question must be answered on two levels: paying attention to the households directly involved and assessing the impacts on the socio-economic structure as a whole.

## 5.1 Impacts on the household actors in the chain

The first and most obvious place to **evaluate the impact is in the very households that are involved in the chains.** As we recall, these households are composed of at least three levels.

At one end of the chains are the **households that receive the care work provided by migrants; many** of them are the direct employers. The impact for those households is undoubtedly positive. The fact that households are resorting to employment or the purchase of other types of services from the market is a response to imperative needs: covering a gap that was not provided for; freeing up time to obtain greater quality of life or to dedicate more time to a professional career; satisfying social expectations associated with differentiation of class, etc. The impact cannot be considered identical regardless of the need provided for. In any case, it can be stated that while care sometimes intensifies a process of social differentiation, in others its addresses pressing needs. In these latter cases, however, **it must not be thought that this work is a miraculous solution to all care needs nor does it signal the end of unpaid care work.** In fact, coordinating the different care providers and covering work not provided by contract work are not covered, and remain primarily a female responsibility.



On the other extreme are the **transnational families** formed by the departure of women. The impact on transnational families is not as clearly positive. Are the preconditions of care improving and is direct care becoming more difficult? Migration is a strategy and receiving remittances allows expectations (or imperative necessities) of material well-being to be met. However, the impacts on care provision are not clear. In fact, in this regard two rather contrasting viewpoints emerge: family breakdown vs. family unification (UN-INSTRAW, 2007a; Paiewonsky, 2008). One view is **an alarmist discourse** on the breakdown of the family provoked by the absence of mothers. **The other highlights new ways families** can function and new ways of transnational mothering that manage to overcome the physical separation.[15] Reality probably falls between the two extremes. **However, to be able to reach a more definite conclusion, more and better data are needed,** since the current data present serious methodological deficiencies.[16] We must also stress the importance of taking a more nuanced look at families, understanding them as social institutions in reconstruction, units of "cooperative conflict" (as Amartya Sen would say) that act within a broader institutional framework. Such families, within the contexts of departure and arrival, are not homogenous, but diverse, since many factors affect whether migration becomes a factor of vulnerability or strength. (Herrera, 2009). Lastly, we must add the potential problem of caring for the elderly that can arise in countries of net emigration that are dealing with an increasingly older population, as is the case for certain Latin American countries (Huenchuan, 2009).

### The sending of remittances and the maintenance of family links

Leaving does not imply abandoning family responsibilities back home. On the contrary, migration often occurs in response to household needs and sending remittances is one of the key ways to contribute from afar.

Women send remittances more consistently than men: they do so more frequently, over a longer period of time, and are more responsive to the changing needs of the household of origin. Moreover, women's remittances represent a larger share of their salaries than men's. 60% of remittances sent from Spain to Latin America in 2006 were sent by women. They sent 39% of their wages, whereas men sent 15% (Moré et al., 2008). The ties expressed in terms of remittance sending are even stronger in the case of domestic employees.

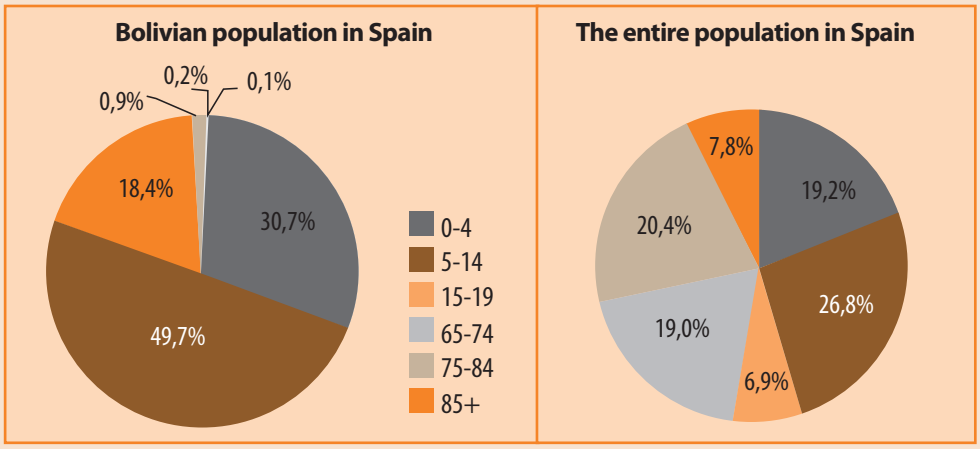
| Remittances Sent | All migrants | Domestic employees from Bolivia, Colombia, Ecuador and Peru |
|---|---|---|
| At least once a month | 19,3% | 58,1% |
| Every three months or yearly | 11,5% | 15,7% |
| Occasionally | 8,2% | 7,8% |
| Not at all | 61% | 18,3% |
| Average amount sent annually | 1.895 € | 2.052 € |

*Source: elaborated with data from National Immigrant Survey (2007)*

15. The first discourse is developed in countries of origin, at a social and mediatic level. In ways which are probably unintended, it is linked with a third discourse on care deficits that emphasizes the global inequalities that allow the richer countries to exploit poorer countries. This last is of a more "academic and elitist" approach (Herrera, 2009; our translation).
16. Among the deficiencies, we can identify the poor quality of information sources, the limited reliability and validity of measurement instruments as well as design weaknesses (lack of comparability, abuse of cross-sectional analysis, and sampling problems). On top of these weaknesses, there is an ideological bias that especially permeates this topic for, as we have stated elsewhere, "it is a matter that touches upon the essential aspects of the social order of gender" (UN-INSTRAW, 2007a; our translation).

There is also a third group to consider: **migrant households in destination countries.** However, analysis of such households is severely lacking (this being another example of the methodological nationalism that prevails in the approach to studying care).[17] Women migrants tend to be considered only as salaried caretakers, without considering their own quality of life, nor that of their families. Despite the lack of studies, it can be argued that, because of their particular demographic structure, these families have unique care needs. Thus, the migrant population's primary demand for care is, above all, for children (in fact, it is thanks to the migrant population that fertility rates are recovering in many destination countries), while for the native population, the need for care is mainly for the elderly. For example, the unpaid care demands of those who receive most care provided by women in Spain is distributed between those aged under 18 (52.8%) and over 65 (47.2%), with the increase in

### Special needs: The demand for care on women aged 18-64




The presence of these migrant women is crucial to help solve the problems that result from the ageing of the Spanish population (for both the work they undertake, and their contribution to the increase in fertility). But these women also have specific care responsibilities: is there any recognition of this situation in terms of public policy? The tendency to hinder their reunification with their own aging parents would indicate not. This policy does not correspond with the almost complete lack of demand for public services that this population segment presents and can make it impossible for them to turn to a strategy frequently used by Spanish natives: the free care labour provided by grandmothers.

These graphs have been calculated assuming that the care needs vary with age (greater for children and elderly) and that caregivers are usually women between 18 and 64 years of age. They refer only to unpaid care.

They show how different groups of the population create demand for unpaid care labour which women must provide: for all women in Spain, demand is distributed more or less equally between what is called juvenile dependency (under age) and elderly dependency (aged 65+), with increasing pressure from the latter (source of increasing difficulties). In contrast, care demand on Bolivian women in Spain comes almost entirely from minors.

17. Kofman and Raghuram (2007) maintain that there are four ways of seeing migrants in relation to care, but that often it is only the first two which receive attention: 1) migrants as caregivers; 2) migrants who leave behind care responsibilities; 3) migrants who take care responsibilities with them; and 4) migrants who have care needs themselves.

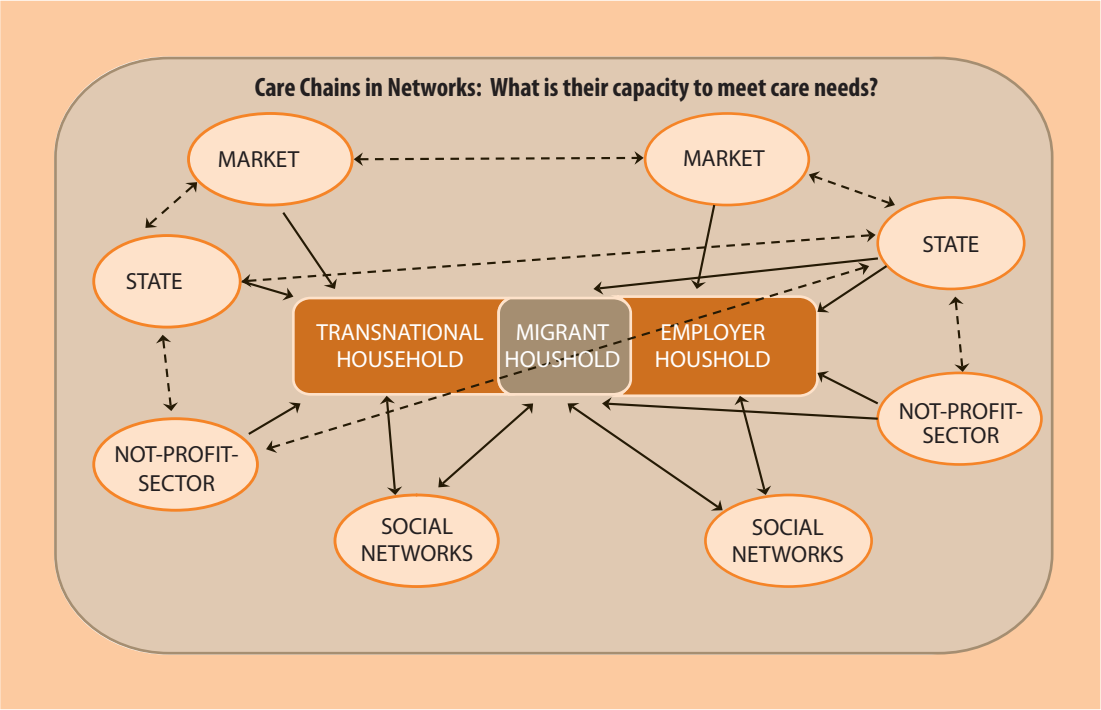
the latter percentage being that which causes greatest difficulties. In contrast, the care demand taken on by migrant women has a very different structure. For example, Bolivian women who live in Spain (largely employed in positions of responsibility for that ageing population) themselves have care needs that are almost entirely related to minors (98.8%).[18] We may well wonder if public policies taken this situation into account – the answer is negative. For example, the tendency to make family reunification more difficult for migrants' elders closes off what for many migrants is the only way of balancing work and family life: bringing grandparents to care for their grandchildren. At the same time, no additional resources are provided so that the children can be cared for in a public care network.

On the other hand, the explanatory factors regarding the difficulties of reconciling work and family life are more acute in the experience of migrant families, particularly so for those who work in domestic service. These factors include: precarious employment (and its corresponding instability, involuntary time and space flexibility, poor access to benefits, rights to family/work balance, and care); a small budget with which to purchase care; and a lack of social networks.[19] Taking all this together, we can state that migrant families face great difficulties in providing care; these are intensified in the case of domestic workers, and do not usually receive adequate attention from public institutions. **There are major violations of what we will term the right to care, and this constitutes a first-order problem** for development for destination countries themselves.

## 5.2 Impacts on the macro level

The impact on a household level is not always positive, especially if we include the experience of migrant families in the destination country. Beyond the household level, what happens at the macro level? We tend to associate care with the family/domestic realm and this limits our understanding of the effects of the globalization of care on development. **Care continues to be understood as a private family matter, not as an essential element of the socio-economic structure as a whole.** If studies of the impacts on households are few, those that go beyond the household and assess the significance for development in a systematic way are in even shorter supply. This research gap is more pronounced in countries of origin, as attention to care has recently proliferated in destination countries. Little analysis on the provision of care refers to peripheral countries, and when it does, it tends to use a conceptual and methodological approach that does not correspond to local realities.[20] **There are multiple analytical weaknesses when it comes to studying the macrosocial impact of the globalization of care:** 1) the invisibility of care has only recently begun to be addressed in central countries; 2) the invisibility of care is intensified in countries of origin and the analytical tools being applied are inappropriate (an even greater problem for rural areas); and 3) the studies about care in general are based on an implicitly nationalist methodology.

18. Prepared by UN-INSTRAW, using data from the municipal registers of Spain's National Immigrant Survey (Instituto Nacional de Estadística, INE) (2008).
19. Thus, in the case of Spain, as Flaquer and Solé set out in their study of the use of social policies on the part of migrant women: "The findings from the work presented here describe a rather bleak landscape. [...] The result is that the problem shifts from Spanish women to immigrant women, so that the latter (and their relatives) experience the greatest lack of care" (2005: 17-8; our translation).
20. In fact, the project which underpins this document arose in response to these shortcomings. Similar programmes are the project on the social and political economy of care in developing countries was launched by the United Nations Research Institute for Social Development (UNRISD, www.unrisd.org).




In the previous section we saw that migration has mixed results in terms of care. In the destination country, the results at best are contradictory: the impact on native households who benefit from migrant women's work is positive, whereas for migrant households it is difficult to adequately cover their own care needs. Many native households remain marginalized because they do not have sufficient purchasing power to privately contract care. In the country of origin, the varied effects of ensuring material and emotional reproduction of the household also have contradictory results. How, then, might we interpret this ambivalence and contradiction in systematic terms?

We can state **there are serious problems in the social provision of care that migration neither creates in the country of origin nor solves in the country of destination. Rather, in both cases, migration merely reveals existing problems.** Put another way, the globalization of care, and particularly the formation of care chains, is exposing existing problems regarding the access and enjoyment of care rights. These problems are caused by poor coordination between the various institutions that should be responsible for guaranteeing their exercise (this is examined below). Or perhaps it would be more correct to say that the problems would be more visible if there were social and political will – currently, there is not.

Seen in this light, the question becomes: **is the globalization of care serving to catalyze the formation of a collective voice to demand public accountability and social responses to these problems,** which are now more visible than ever? The answer is disappointing. As Diaz Gorfinkiel remarks, "Perhaps the creation of the care labour market has allowed no other important issues to be redefined" (2008: 87; our translation).[21] We are witnessing a process that

21. This same question was raised by the author at the conference "Migrant women: women who care: the new sexual division of labour" (Madrid, 1-3 December 2008, ACSUR-Las Segovias/Platform 2015 and beyond/UN-INSTRAW). And the answer, addressing destination countries (by the author) and origin countries (by Denise Paiewonsky) was clearly negative: instead of pushing to demand responsibilities, migration functions as an individualized escape valve. See the presentations found at www.un-instraw.org/es/md/global-care-chains/2008-diciembre-1-2-3.html.

we can call the **double privatization of social reproduction,** in which the responsibility for guaranteeing social reproduction is considered a household responsibility, and where different resources combine – such as unpaid work, public services, and increasingly the purchase of services – to result in the commodification of care.

Providing for care needs is doubly privatized. First, a significant amount of care that was previously performed for free is now purchased in the market place. In fact, many recent public care benefits have been designed with a degree of privatization unknown in other pillars of the welfare state. The resource boom in the recruitment of domestic workers, the growing presence of businesses in the industry, and the widespread privatization of public services indicate that there is a process **of commodification of care.** This phenomenon takes different forms in different countries. While in the richest countries the care market is fairly homogeneous and is characterized by its duality (the majority of the workforce is employed in the most precarious subsectors, with only a minority of occupations being well-respected and offering good conditions), in middle-income countries the market of quality services is underdeveloped and the bulk of care is provided by the most informal end of the labour spectrum (Razavi, 2007a).

### The Dependency Act: Opportunities and challenges

A law known as the Dependency Act (39/2006) was passed in Spain in 2006. It recognizes individual, universal and subjective rights for people in a situation of dependency to receive care, and it articulates various service and monetary benefits (domestic help, telecare, day and night centers, residences, etc.). The Act signifies a breakthrough in the construction of the fourth pillar of the welfare state. However, several factors threaten this progress:

- the narrow understanding of "dependence" which leaves out a wide range of situations;
- poor budgeting and coordination between the various administrations involved;
- the degree of privatization of services permitted by the law and found in its application, which results in the varying quality of services and promotes precarious employment;
- the creation of the legal figure of non-professional care in the family which, although declared an exceptional resource, in practice, makes the poorly paid and undervalued work of family caretakers and domestic labourers (often migrants) a fundamental pillar of the law;
- the establishment of a system of co-payment that encourages the informality of household work and makes the population at large pay for the enjoyment of a right;
- the application of the law is stratified by conditions such as migratory status, region of residence, socio-economic status, level of acknowledged dependence, sex, etc.

Second, care is privatized because it is managed within the household sphere, and the coordination of various resources is guaranteed in accordance with diverse strategies of survival, reconciliation and social promotion.[22] **Ensuring care remains a "domestic issue",** rather than a responsibility that has been translated into a right to care. Family problems and expectations are to be resolved by families themselves, based on their flexibility, which in turn is determined by their access to public services, their employment situation, purchasing power, educational resources and information, social networks, etc. All this results in an increase in social inequalities, particularly between households with and without migrants in countries of origin, and between employers and employees in destination countries.

This dual process of commodifying care and strengthening the domestic sphere means that care continues to be sidelined from public debate. When it does leave the confines of the household, it does so in the form of individual buying and selling, not as a right. Care continues to be invisible. This is linked to the fact that gender inequality is not disappearing, but rather taking on new forms. Care continues to be associated with women in the twin sense outlined above, both symbolically and materially. But the differences between women themselves continue to widen, in what some authors have called "a sexual and ethnic re-stratification" of care work. **In this way, the sexual division of labour has acquired new global dimensions.**

All this leads us to one final question: in countries of both origin and destination there have been changes in gender relations that have provided the basis for the globalization of care. In destination countries, such changes have been a key factor in the collapse of the previous care model; in countries of origin, the feminization of migration is linked to an earlier process of increasing autonomy and access to women's rights that thus allows women to assume greater leadership in the migration process. These changes bring to light latent problems associated with the lack of public accountability in the provision of care. However, the fact that the globalization of care exposes structural tensions does not necessarily result in a public commitment to remedy these shortcomings, but rather in an intensified process of privatization of social reproduction and a reconfiguring of the sexual division of labour. **Is the old tactic of avoiding public care responsibilities through an unfair distribution of labour which takes on a new transnational dimension?**

22. In our previous writings on remittances and their use, we have discussed this same process in which migration is undertaken as an individualized response to the lack of basic human rights. Remittances are used to make purchases of health-care services and education on the market, thus compensating for the absence of a social safety net (UN-INSTRAW, 2008; 2009).

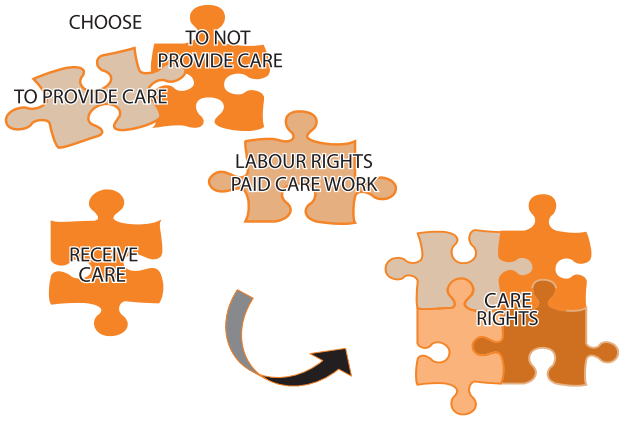
# 6. Reversing the link between care and exclusion: Care rights

The primary policy challenge faced in the social organization of care in the era of globalization is recognizing and addressing the long-standing connection between care, social inequality and exclusion from citizenship.[23] This link, perpetuated worldwide although with undeniable differences depending on the era and location in question, is today taking on new and very serious transnational dimensions.

**The link between care, inequality and exclusion constitutes a core component of the various existing care regimes**. As Izquierdo explains, we think of "citizenship based on exclusions, all of which are related to different dimensions of care" (Izquierdo, 2003: 5; our translation). **And this is systematically tied to gender inequalities** and the relegation of the responsibility of care to women. In capitalist societies, care regimes are undergoing major changes that include an intensified privatization of social reproduction and a refashioning of the sexual division of labour. This, in turn, has major global repercussions and increasingly positions immigration status as an axis on which in the link between care, inequality and exclusion, together with gender and class – two other longstanding factors – pivots.

## 6.1 Articulating the care to right as a public responsibility

The link between care, inequality and exclusion is created by default in that it is the direct result of the absence of care rights. **This vicious cycle can be broken with the creation of a right to care that constitutes a core component of society and, consequently, of development processes.** Development is understood as UN-INSTRAW has previously defined it: "the comprehensive right to enjoy the full range of human rights" (2008: 22). Care rights must be an individual and universal right enjoyed by all. This holistic perspective, which must inspire development processes, is rooted in a two-sided reality: one in which care is both received and provided.

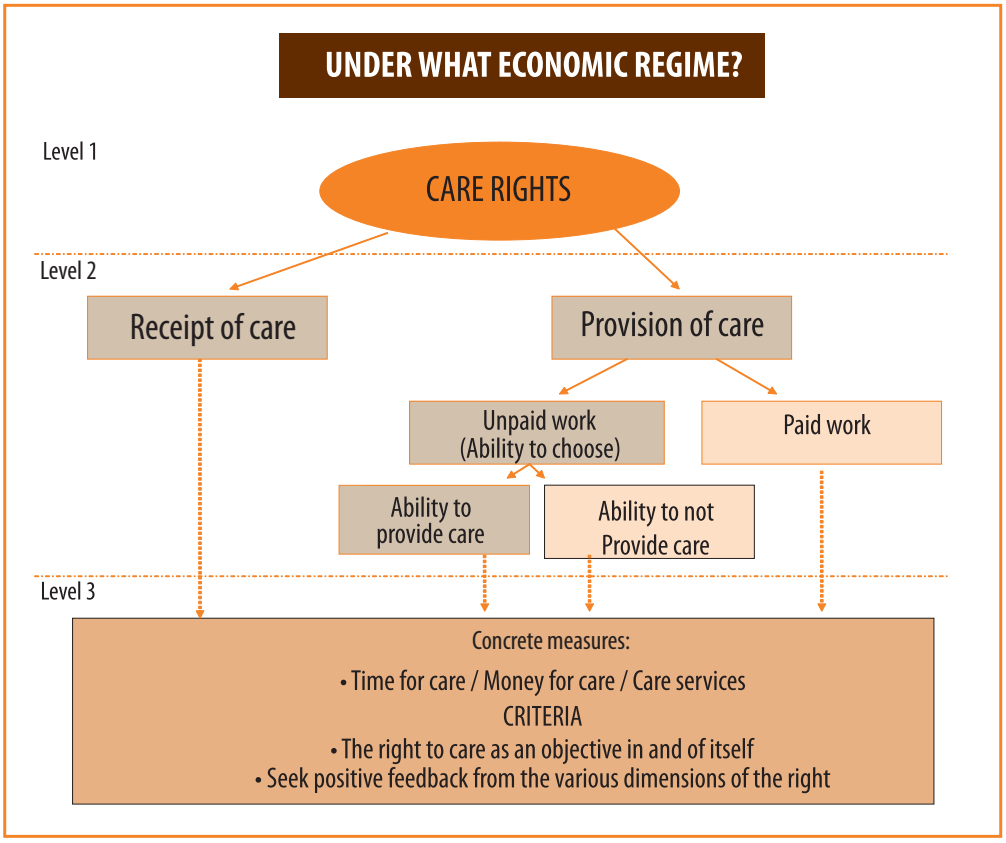



This right, which did not exist previously, even in conceptual terms, but is on the verge of being created, would encompass: 1) **the right to receive the care needed in different circumstances**

23. Citizenship is understood here as being able to access one's rights, i.e. one's rights are formally recognized and one is able to effectively exercise them. There is no clear line between inclusion and exclusion but rather a thread of continuity joins the denial of one's rights, their formal recognition and their full exercise. A number of economic, social, political and cultural factors are at play here.

and at different points in one's life, ensuring that this basic need is met regardless of an individual's access to income or family or personal ties. 2) With respect to unpaid care, **the right to choose whether or not one wants to be a caregiver,** combining the right to provide care (in dignified conditions) with a right to not provide care.[24] And 3) **the right to dignified working conditions in the care sector,** eliminating penalties in the sector, with particular emphasis on domestic work.[25]

**Care rights can be viewed as a guiding principle of social structure.** Starting at the first level, the specific rights that coincide with the receipt of care, the unpaid provision of care and work in the care sector (second level) should be identified; and last, debate should ensue concerning what measures could be taken (third level).




24. This calls for a revisiting of the dimensions of protection that must be provided by welfare states. Social protection has often only been provided to guarantee an adequate degree of "decommodification": that is, the ability to remove oneself from the market (from paid work) and maintain an acceptable standard of living. This assumes that the only social risks that warrant protection are those that related to market-based work, not those that affect non-market care work. The idea of decommodification (which would guarantee the right to care to some extent, since caregivers would not be subject to the state of the job market) must be complemented by that of defamilization. The latter is understood as the ability to stop providing care within the household knowing that schemes will be in place to ensure that care needed is in fact provided (i.e., a right to not provide care).
For purposes of clarity, a distinction is made between receiving care, providing care on an unpaid basis, and providing care for pay. Still, it should be kept in mind that these three dimensions are not completely separate from one another but remain connected. It is in fact based on this connection that political pressure can and must be exerted. For example, many of the measures that enforce the right to care, to the extent they provide the material conditions to do so (availability of time, allowing for departures from the labour market without detriment to the caregiver's professional career while ensuring income; consideration for the time devoted to caregiving as time credited to benefit systems; monetary benefits for domestic caregivers, etc.), are themselves redefining the boundary between paid care work and unpaid care work.
25. The implementation of a right to care requires the gradual introduction of benefits and services that will slowly be extended to the entire population. Accordingly, decisions as to which social groups will receive priority must be made, but the gradual introduction of these benefits and services must not be confused with a desire to target specific groups: this does not guarantee rights, but rather ensures partial protection in response to exclusion.

Articulating the right to care **assumes putting an end to the government's frequent role of substituting families, and removing care from targeting policies.** By failing to recognize care as a civic right (as was previously the case for education and health care previously, and today remains so in many countries), the State tends to play a substitutory role to cover shortcomings faced by households. It steps in when an individual is unable to secure access to care with his/her own resources: social networks fail and no income is available. Care is part of targeting policies aimed at preventing or mitigating situations of social exclusion and poverty. The proliferation of scattered, fragmented measures and services are typical of systems in which universal rights are non-existent and from which large segments of the population are excluded. When we talk about a right to care, for it to be just that (recognized and asserted in conditions of equality), it must constitute a universal right; this thus incompatible with a targeting policy.[26]

In the longest-standing welfare states, the three classic pillars (health care, education and social protection) are being complemented by a "fourth pillar" that recognizes the right to receive care in situations of dependency. This dimension of well-being is very closely tied to the ageing of populations, and constitutes the first few steps toward recognizing the right to receive care. (It is currently limited to situations of dependency, a term that generally includes individuals with disabilities, regardless of age).[27] Moreover, so-called work–life balance policies are also being developed.

Care rights can be articulated in various manners. One way to categorize the various measures is to make a distinction between the time devoted to care, the money used for care and care services. Several of the most heated debates concerning each area are addressed below:

### 6.1.1 Time for care

Benefits are needed to free up time from employment so that it can be devoted to providing unpaid care (maternity and paternity leave, breastfeeding leave, family care leave, shorter workdays and so on). These benefits may be paid or unpaid, just as the time freed up from employment may or may not be credited toward social security. Unpaid benefits are often accused of reinforcing the role of cost-free caregiving assumed by women and accentuating their labour and social vulnerability. Most are equally recognized for both men and women but they constitute rights asserted almost exclusively by women. The exception to this rule is paternity leave, which is not widely recognized and, if it is, it is equivalent to a length of time in utter disproportion to that given for maternity leave.

These benefits are based on paid work in the formal sector,[28] and as such, they are not highly relevant or applicable to large-scale contexts in the informal sector. Lourdes Benería (2008) explains that thinking about organized care services in terms of the household may be more relevant since, in the absence of a specific workplace, it tends to be the primary point of reference

26. The implementation of a right to care requires the gradual introduction of benefits and services that will slowly be extended to the entire population. Accordingly, decisions as to which social groups will receive priority must be made, but the gradual introduction of these benefits and services must not be confused with a desire to target specific groups: this does not guarantee rights, but rather ensures partial protection in response to exclusion.
27. This is a topic of heated debate: where should the government focus its efforts: on care for those with disabilities or on minimizing the loss of autonomy caused by a disability? That is, should its efforts focus on the right to receive care or on promoting the right to an autonomous life? This relates to the manner in which beneficiaries are viewed: whether their dependency is viewed as an individual, static situation or as a result of the ability of social quarters to accept individuals whose bodies or minds work in a different manner (thereby minimizing the dependency caused by their so-called "functional diversity").
28. These benefits are generally tied to employment by a third party, although some are gradually being extended (maternity benefits, in particular) to self-employment.

for others in general and women specifically. This criticism is increasingly applicable in regions such as Europe where a high level of job insecurity blurs the line between the formal and informal labour markets and multiplies the amount of self-employed persons.

### 6.1.2 Money for care

These benefits are provided in consideration for caring for a member of the family. By their nature, they blur the line between unpaid and paid work in the care sector and are considered highly controversial. Some feel that they may contribute to the instability of the sector or constitute a way to take advantage of care that is not entirely free but indeed poorly paid. This perspective is countered by the argument that they serve to assign a value to the work that is indeed already performed in the household by women, and to afford them certain financial independence. In this connection, the crux of the problem lies in how this type of work, which already exists, should be recognized and valued, and how the economic and social rights of those who perform the work can be ensured without reinforcing this situation (which is how the bulk of care is provided).

Here lies the classic debate around salaries for housewives. This debate, which was originally more aggressive in its demands than was actually feasible, has today been recast based on two lines of thought. In terms of the oldest welfare states, the possibility of recognizing and assigning a value to the concept of informal home-based care provided for dependent individuals is being carefully considered. In Latin America, a number of countries (like Venezuela and Ecuador) recognize the productive role of domestic work in their constitutions, which intertwines with the importance of the active role of women in lower-income segments of the population as the lynchpin of their homes and communities. Against this backdrop, measures such as temporary financial allowances are articulated and retirement pensions for housewives are discussed. One example is the "Josefa Joaquina Sánchez" Neighbourhood Mothers' Mission (Misión de Madres del Barrio "Josefa Joaquina Sánchez") in Venezuela, in which the monthly assignment of 80% of a minimum wage is proposed as "economic compensation for the provision of care [which] is a recognition […] of their economic value and social contribution" (Carosío, 2008: 73; our translation).

### 6.1.3 Caregiving services

Instead of facilitating care provided by family members (by providing time and money for such care), caregiving services to be provided in the household (for example, paid domestic care) or in institutionalized spaces (retirement homes, childcare centres, day or night care centres, temporary care centres, extracurricular activities for children, etc.) could be made available. Private companies could be forced to provide these types of services, much as they are in the case of childcare centres at which a certain number of employees are hired.[29] Alternatively, the government could assume this responsibility whether directly by providing the services itself or indirectly by financing private centres (managed by businesses or NGOs) or by granting monetary benefits to finance the free purchase of care on the market. A key debate surrounds what level of privatization of these services is desirable and if they should be accompanied by a co-payment to be made by care-users (unlike other rights such as the right to health care, in which services are often entirely free). This is a debate that we will revisit later on.

29. These services tend to be associated with the female employees' role as mothers and are non-existent for men, and in addition, only cover childcare. The service is interpreted more as a way to guarantee a woman's right to work.

## 6.2 Criteria for identifying specific measures

The decision as to what specific policies should be adopted to articulate care rights must be the product, as previously stated, of a democratic debate. The voices of the leading subjects in care relationships must guide this discussion, breaking the traditional dynamic of denying them a voice (in the sense of capacity for political incidence) and exclusive recognition of the social agents articulated around paid work: no debate around care regimes can consider only the voices of unions and employers as legitimate. Several guiding criteria that will assist discussion in this area include the following:

### 6.2.1 Care rights must be an objective in and of themselves

The very objective of establishing care rights is to have this vital dimension **recognized as a basic component of well-being and citizenship.** As it has a goal itself, **any measures adopted should not be created as instruments to pursue other objectives.** This counters a fashionable argument in favour of viewing care as a means to investing in human capital and therefore improving productivity and development (if understood as commercial growth). This argument is used both by health-care and child education programmes associated with the so-called New Social Policy (in which care is used as an instrument for increasing the stock of human capital into the future) and work–life balance policies (as a scheme for efficiently leveraging the human capital of women). The problem of this argument is that, from the outset, it excludes the allocation of public resources for those who are not considered potentially productive in a market sense.[30]

### 6.2.2 Differentiating care rights from other rights

Although the right to care, as a guiding principle, cross-cuts many other social rights, the specific measures used to articulate them must be differentiated from others such as the right to education and the right to health care. **A distinction between health care, education and care, and so on, results in specific configurations for welfare states and social protection systems.** For example, in European countries, the interactions between the "fourth pillar" and the health-care system are confusing. Whether or not childcare for children aged three or less constitutes part of the education system is also under debate. Last, this confusion and ambiguity shows that care, although fragmented and scattered, has become a topic of public debate but its emergence is so recent that it lacks a clearly defined focus.

Establishing boundaries between these rights is related to the distinction made between care work and other professional competencies. Professionalization – defined as a clear identification of tasks, working conditions and required training – tends to shift the perception of the activity from a generic version of care to one of more skilled nature.[31] The risk posed by this trend in professionalization is that, by default, care can end up being associated with all-purpose tasks that do not require skill.

---

30. It is therefore not generally used in policies that target the elderly, the disabled or similar groups. It thus becomes a very weak argument when attempts are made to apply it to other, non-mercantile areas, for example, in justifying the investment of resources in promoting the co-responsibility of men and women in the household to better leverage the caregiving capital of men.
31. For example, in the context of more developed welfare states, the education system is understood to fulfill an educational function in and of itself, and not one of care. There has been debate over the appropriate age at which children should begin to attend school (and consequently the profession of a child educator), in which childcare was proposed.

### 6.2.3 Positive feedback from the various dimensions

Care rights are multidimensional and their various facets are not independent from one another: if an individual receives care, someone else is providing that care; whoever is providing care, also needs to receive care; different working conditions for domestic work means different family caregiving abilities; and so on. This interrelationship can easily become contradictory in nature.

One of the most common contradictions seen is the clash between the right to receive care and the right to not provide care. Two examples follow. On the one hand, the time and money devoted to care without outside help guarantee the provision of care by imposing it on the household. This occurs, for example, with the development of solutions such as leaves of absence from work to care for family members, and in contexts where there is a clear lack of retirement homes: if you choose not to take leave, what is the alternative? On the other hand, the conditional transfer programmes typical of the New Social Policy seek to ensure the well-being of children living in poverty by exercising control over the role of mothers. In doing so, they reinforce the role of mothers as unpaid caregivers.[32] In both cases, the right to choose by either a man or woman is denied, but it is experienced differently by men and women. This sex-differentiated denial can occur either directly (in cases where mothers themselves – and not fathers – are charged with the responsibility of managing conditioned cash transfers), or indirectly (in cases where benefits can be exercised by either women or men but it is almost always women who do so).

The contradiction that lies between receiving and providing care can also surface in paid work. For example, the more privatized and commodified the services are (domestic care, nursery schools, retirement homes, etc.), the more they tend to promote precarious labour. Likewise, extending care services to the poorest quintiles is often carried out by taking advantages of work in the voluntary or informal sector.[33] Another common contradiction is the age-old question of who takes care of the caregivers?[34]

**The interrelationship between the various facets of the multidimensional right to care may assume the form of positive feedback.**[35] The main objective is to therefore understand the interconnection that inevitably exists between these various facets and to determine a process that will mutually reinforce them and not discard them one after another. **We must thus recognize that no clear divide exists between those who provide care and those who receive it but rather** care occurs within a context of interdependent social relationships and that **no one can enjoy rights in only one of its two facets, but rather in both concurrently.**

32. Yet once again, this is done without being made explicit or being brought into discussion. Villatoro Saavedra (2007), for example, in his exhaustive review of these kinds of measures in various Latin American countries, on only one occasion pointed out the work overload this means for women; it is only mentioned in psychosocial and cultural terms, never in economic ones. One critique of these measures is provided by Molyneux (2007). A comparative analysis of these programmes in Chile and Mexico is offered by Arriagada and Mathivet (2007).
33. As, for example, has been debated in the case of the Children's Care Network (Red de Estancias Infantiles) promoted by Mexico's Secretariat for Social Development (Secretaría de Desarrollo Social).
34. This shift, which by recognizing women as caregivers disregards their own care needs, is easier if applied to female migrants. As stated above, these women tend to be recognized solely as care agents, never as care recipients.
35.The more nursery schools there are, the more feasible it will be to choose not to provide domestic care for free. If these services are provided as public services with individuals hired to work in decent working conditions, this positive shift in the sector would help improve the quality of care offered. Recognizing labour rights in the care sector and guaranteeing decent conditions for domestic care in and of itself ensures that workers are cared for.

# 7. Care rights – under what economic regime?

Understanding care rights from a holistic perspective and not as a "right specific to any one group" (Pautassi, 2007; our translation) brings us to a final question of paramount importance, with a much larger scope than the debate on what specific measures should be implemented in the short-to-medium term: **under what economic regime can care rights be articulated and exercised?**

This question must be answered on two separate levels. First, on an organizational level: if the objective is to redistribute the burden of care assigned to households (and subsequently to women), **in what other way can we propose to structure the so-called "care diamond"?** What is the role of each institutional scenario and agent: the market, the government, households, social networks and the non-profit sector?

Serious difficulties exist in asserting care rights using for-profit market services. Within the care sector, we have witnessed a tendency to violate labour rights. Why is the sector penalized in this fashion? Insofar as it is a labour-intensive sector, where human relations are of central importance and where the pace of work is non-negotiable (as it is based on physiological constraints), using technology to perform human work to increase productivity or to increase the "quantity" of care provided per work unit is quite complicated. This situation has historically been defined as the "cost disease", which turned care into an uncommodifiable activity, preventing development-oriented logic from prevailing in the sector (where commercial growth would be considered the driving force of economic development).

However, care has been progressively commodified. One way in which the contradiction between care and business profitability has been countered has been with the gradual decline of working conditions. Why do the workers themselves accept this decline? One source of pressure comes from the sense of responsibility felt by caregivers for the well-being of others, which prompts them to perform the work without it being recognized. This is an example of the **"use and abuse" of women caregivers.** The increase in the cost of service is another factor, as it makes the quality of the services received vary greatly depending on the purchasing power of the "clients". Overall, broadening the scope of care rights seems to call for serious limitations to be placed on how commercial matters and a profit-oriented logic will play out. **Guaranteeing equal access to the care needed without impinging upon labour rights requires that care be provided by entities other than businesses.** This thus opens up debate as to which entities these should be and what changes will be required by these non-market areas: the government or the non-profit sector?[36] What kind of State and with what legitimacy? The debate goes beyond these elements to deal with the forms and processes of the democratization of spheres of economic activity, as for political and social spheres.

36. A UNRISD study shows that penalties are significantly reduced in the public sector: "In several countries the significant care penalties found in the private sector are comparatively reduced, though not eliminated when performed in the public sector" (Razavi and Staab, 2008: 15).

On a structural level, the question is, then, what logic should be followed to determine how the interplay of agents must be structured. Looking at socio-economic systems organized according to the logic of accumulation (which ultimately aims to ensure the proper functioning of processes of capital accumulation), is it feasible to have care rights as a guiding principle of the social structure? **That is to say, can a socio-economic system that pivots on the accumulation of capital be responsible for ensuring care rights?** To what extent has denying the right to care served as an indispensable factor in containing structural tensions within an economic system that, by prioritizing the logic of accumulation, inhibits a sense of social responsibility in caring for someone's life?

Recognizing a genuine right to care and creating the conditions to ensure it can be exercised calls for comprehensive social changes and for certain aspects at the very heart of the socio-economic system to be reconsidered from this viewpoint, including: the organization of habitable spaces and urban development models, as mentioned above, and the organization of time. A precondition for care rights is the availability of time: to provide care, to receive care, to care for oneself, to involve oneself in reciprocal care relations that go beyond the dichotomy of providing and receiving care, etc. That is to say, care has a cross-cutting quality (it effects the entire lifespan) and is unpredictable (it can extend beyond the time allotted for a specific resource, and sets the pace of work that can be planned). Furthermore, it cannot be reconciled with the fact that spare time is subject to the market's "time clock", as is the case today.

This essential renegotiation of free time calls for the concept of standard economic integration to be questioned. A standard or ideal[37] worker is characterized as a **"dependable worker bee"** (Carrasco et al., 2004; our translation): one who does not have care needs or responsibilities of his or her own and who shows up everyday ready and available to work. This is the farce that part of the population can play into as long as a hidden network of care work covering all of their needs and responsibilities exists. So-called "work–life balance problems" are rather processes by way of which light is shed on the structural impossibility of expanding this model of the standard worker. Here, the employers' demands on workers' time (and mobility) collide with the care needs and responsibilities of these very employees. This is where reconciliation policies come into play, which, given prevailing pressures, end up giving priority to the commercial world. Ultimately, their goal is not to ensure a right to choose per se, but rather to ensure the ability to join the workforce.

If care rights are to be consolidated, **care workers must be recognized as individuals who have their own care needs and responsibilities in terms of caring for others in their own lives.** The ability of the market to regulate itself in this sense, when it must simultaneously ensure the success of the process that underpins its very existence (capital accumulation), is thus vitiated from the outset. Last, the current implementation of the productive-worker model in society is incompatible with care rights.

37. We use the term "standard or ideal" here in the sense that it represents the model upon which the labour market is built, and toward whom social and economic rights are geared. It is also the mould that women are to try to fit when they join the workforce, used as a model of a form of development that is understood as commercial growth alone.

In conclusion, an inherent contradiction exists not only in the attempt to guarantee care rights through commercial growth, but also in the will to do so in a system where the logic of accumulation constitutes the pivotal axis of its socio-economic organization. Ultimately, these matters, beyond the efficiency, effectiveness and equity of specific measures, frame the discussion within a structural dimension: what economic regime can support the introduction of care rights? The possibility of reconciling the logic of accumulation as the organizational basis of a socio-economic system with care rights seems unlikely. Constant digressions to the productivist argument of investing in care to invest in human capital show that in the care–accumulation debacle, the end goal (and that which will prevail in the case of conflict) is the proper functioning of for-profit commercial activity. The debate needs to be urgently redirected toward this structural framework and the care rights must not be viewed as a clean decision based on the most pertinent measures within the range of options available.

# 8. A final consideration

The rights focus set out in this document was recently discussed at the meeting held in Lima with researchers working on the "Creating networks: Latin American women in global care chains" project. There, we debated the possibilities and weaknesses of this proposal – and made adjustments to it. Because of time pressure, it has not been possible to rewrite this conceptual framework based on the new ideas developed; we provide here a brief explanation, although it cannot do justice to the richness of our shared reflections.

By addressing the connection between care, inequality and exclusion, we are locating care as a key element of differentiation between social groups. **It is privileged social groups who are able to escape the precarious care forced on the rest of the population.** As we face the expansion of precarious care structures, **decent care should be located as a claim of inalienable minimal norms** within any process of economic translation that claims people's welfare as its core. And **care would become an inherent part of all redistribution policies.**

The claim for the right to care inherits the problems associated with claims for rights made by liberal or Europeanizing feminisms in Latin America. One key problem is the contrast between formal recognition and the true exercise of rights. While many Latin American constitutions recognize a very broad range of rights, these rights remain in rhetorical limbo for most of the population. **By demanding a right to care, are we broadening that "well-intentioned literature" without achieving any effective impact? How to translate this claim into something concrete and achievable?** A second problem is the individualized character of the claims in terms of rights. On the one hand, this individualist bias clashes head-on with the reality of care, which is precisely characterized by the interdependence between people at different times in their lives and in different facets of their well-being; this is also the case because it occurs within a framework of social relationships. How are individual claims to be made on inherently interdependent facets of one's life? Care is always provided within interdependent relationships – the question is in regard of the symmetry or asymmetry surrounding that interaction. **How to achieve a demand for care that is based on mutual commitment and collective organization, avoiding a liberal or individualist rights focus?** On the other hand, it is precisely this tension between the individual and the community that underpins certain political conflicts which places decolonization and "the Western conquest model in citizens' rights" (Monasterios, 2007; our translation) in conflict. **By demanding (an individual) right to care, are we deepening this divide, perpetuating the gap between struggles for recognition (decolonization) and redistribution (of resources, jobs, care)?**

Could an exit to this impasse be found by speaking of "fair care"? The demand for a fair care regime seems to have greater political strength, and to open the possibility of allowing a convergence of both perspectives on transformation. The simplest solution may be to agree that current care regimes are unjust. This is because care is invisible, and the matter is resolved in the private-domestic sphere; because there is a marked inequality in access to and distribution of care; because care denies the reality of interdependence and exalts the perverse illusion of self-sufficiency (of the dependable worker bee, of homo economicus); because it crosses the sexual division of labour with other axes of inequality; because the agents involved have no say

in decision-making process. **Following the recognition of the unfairness of existing regimes, we must urgently demand decent care as an immediate, inalienable demand, and we must local fair care as an objective for change.**

Locating care at the center of socio-economic systems is a good match for a reestablishment of development in terms of the **good life (sumac kawsay) or living well (suma qamaña),** as they appeared in recently approved constitutions (the Ecuadorian and the Bolivian, respectively). These ethical and moral principals provide room for the idea that we tried to set out earlier: first locating the right to care as an orienting principal of social structure, then reconsidering the economic regime where this may be able to exist. But these principals provide a collective aspect to our idea, considering it as a "harmonious and holistic relationship between human beings and nature" (León, 2008: 36; our translation) which may be able to escape from the individualist tradition of so many rights foci.

**Our demand has been redefined and strengthened: for a global regime of fair care.**

# Bibliography


- Anderson, Jeanine (2008), "Nuevas políticas sociales de producción y reproducción". In Arriagada (ed.), Futuro de las familias y desafíos para las políticas, Serie Seminarios y Conferencias, ECLAC, No. 5. Available from: en www.eclac.org/publicaciones/xml/9/32699/ssc_52_Familias.pdf.
- Andia Fagalde, Elizabeth (2009), El cuidado: un "trabajo" que contempla la dimensión afectiva y la racional: genealogía del cuidado en Bolivia, (forthcoming on www.un-instraw.org)
- Arriagada, Irma and Charlotte Mathivet (2007), Los programas de alivio a la pobreza Puente y Oportunidades. Una mirada desde los actores, Serie Políticas Sociales, ECLAC, No. 134. Available from: www.eclac.org/publicaciones/xml/9/28599/sps134_lcl2740.pdf
- Benería, Lourdes (2008), "The crisis of care, international migration, and public policy", Feminist Economics, No.14, Vol.3, pp.1-21.
- Budlender, Debbie (2008), "The Statistical Evidence on Care and Non-Care Work across Six Countries", Gender and Development Programme Paper, No.4, Available from: www.unrisd.org.
- Carosío, Alba (2008), "Feminizar las políticas para un desarrollo humano sustentable y emancipador", Umbrales, No.18, pp.45-78.
- Carrasco, Cristina, Maribel Mayordomo, Màrius Domínguez, and Anna Alabart (2004), Trabajo con mirada de mujer. Propuesta de una encuesta de población activa no androcéntrica, Madrid: CES.
- Díaz Gorfinkiel, Magdalena (2008), "El Mercado de trabajo de los cuidados y la creación de las cadenas globales de cuidado: ¿cómo concilian las cuidadoras", Cuaderno de Relaciones Laborales, No.26, Vol.2, pp.71-89.
- ECLAC (ed. Sonia Montaño) (2007), El aporte de las mujeres a la igualdad en América Latina y el Caribe, Santiago de Chile. Available from: www.choike.org/documentos/cepal2007/03cepal2007.pdf.
- Esplen, Emily (2009), Gender and care, BRIDGE Cutting Edge Pack, Available from: www.bridge.ids.ac.uk/reports/CEP_Care_OR.pdf.
- Flaquer, Lluís and Carlota Solé (2005) "Prefacio". In Solé and Flaquer (eds.), El uso de las políticas sociales por las mujeres inmigrantes, MTAS-Instituto de la Mujer. Available from: www.migualdad.es/mujer/publicaciones/docs/mujeres%20inmigrantes.pdf.
- Herrera, Gioconda (2009), "Impactos en origen: nuevos roles familiares, impacto en los regímenes de protección social y respuestas desde las políticas públicas", Curso Migración, género y desarrollo, 23-26 March, Santa Cruz, FIIAPP/UN-INSTRAW/AECID.
- Huenchuan, Sandra (ed.) (2009), Envejecimiento, derechos humanos y políticas públicas, ECLAC. Available from: www.eclac.org/publicaciones/xml/4/36004/LCG2389-P.pdf.
- IOM (2008), World Migration 2008: Managing Labour Mobility in the Evolving Global Economy.
- Izquierdo, Maria Jesús (2008), "Los cuidados y las cadenas vistas desde los países de destino", Mujeres que migran, mujeres que cuidan: la nueva división sexual del trabajo, 1-3 December. Video Available from: www.un-instraw.org/es/md/global-care-chains/video-mujeres-que-migran-mujeres-que-cuidan-2.html.
- Jiménez Zamora, Elizabeth (with Cecilia Salazar) (2009), La organización social de los cuidados en Bolivia (forthcoming on www.un-instraw.org).
- Kofman, Eleonore and Parvati Raghuram (2007), "The Implications of Migration for Gender

and Care Regimes in the South", Social Policy and Migration in Developing Countries, UNRISD-IOM-IFS workshop. Available from: www.unrisd.org.
- León T., Magdalena (2008), "Después del "desarrollo": "el buen vivir" y las perspectivas feministas para otro modelo de América Latina", Umbrales, No.18, pp.35-44.
- Levitt, Peggy and Nina Glick Schiller (2004), "Conceptualizing Simultaneity: A Transnational Social Field Perspective on Society", International Migration Review, No.36, Vol.3.
- Martínez Franzoni, Juliana (2007), Regímenes de bienestar en América Latina, Documento de Trabajo, No. 11, Fundación Carolina-CeALCI. Available from: www.fundacioncarolina.es/es-ES/publicaciones/documentostrabajo/Documents/DT11.pdf.
- Milosavljevic, Vivian and Odette Tacla (2007), Incorporando un módulo de uso del tiempo a las encuestas de hogares: restricciones y potencialidades, Serie Mujer y Desarrollo, No. 83, ECLAC, www.eclac.org/publicaciones/xml/1/28541/lcl2709e.pdf.
- Molyneux, Maxine (2007), "Change and Continuity in Social Protection in Latin America: Mothers at the Service of the State?", Gender and Development Program Paper, No. 1, UNRISD, Available from: www.unrisd.org.
- Monasterios, Karin (2007), "Condiciones de posibilidad del feminismo en contextos de colonialismo interno y de lucha por la descolonización". In Monasterios, Stefanoni, and Do Alto (eds.), Reinventando la nación en Bolivia. Movimientos sociales, estado y postcolonialidad, CLACSO/Plural Editores.
- Montaño, Sonia (coord.) (2007), El aporte de las mujeres a la igualdad en América Latina y el Caribe, CEPAL: Santiago de Chile
- Moré, Iñigo, with Alfonso Echazarra de Gregorio, Bouchra Halloufi and Ramona Petra (2008), Cuantificación de las remesas enviadas por mujeres inmigrantes desde España. Available from: www.remesas.org.
- Paiewonsky, Denise (2008), "Impactos de las migraciones en la organización social de los cuidados en los países de origen: el caso de República Dominicana", Jornadas mujeres que migran, mujeres que cuidan, Madrid 1-3 December. Available from: www.un-instraw.org/es/md/global-care-chains/2008-diciembre-1-2-3.html.
- Pautassi, Laura C. (2007), El cuidado como una cuestión social desde un enfoque de derechos, Serie Mujer y Desarrollo, No.87, ECLAC. Available from: www.eclac.org/publicaciones/xml/5/31535/lcl2800.pdf.
- Razavi, Shahra (2007a) "Political and Social Economy of Care in a Development Context: Conceptual Issues, Research Questions and Policy Options", Gender and Development Programme Paper, No.3, UNRISD, Available from: www.unrisd.org.
- _____ (2007b), "The Return to Social Policy and the Persistent Neglect of Unpaid Care", Development and Change, No.38, Vol.3, pp.377–400.
- Razavi, Shahra and Silke Staab (2008), The Social and Political Economy of Care: Contesting Gender and Class Inequalities, Expert Group Meeting on "Equal sharing of responsibilities between women and men, including care-giving in the context of HIV/AIDS". Available from: www.un.org/womenwatch/daw/egm/equalsharing/EGM-ESOR-2008-BP-3%20UNRISD%20Paper.pdf.
- UN-INSTRAW (Carlota Ramírez, Mar García Domínguez, and Julia Míguez Morais) (2005), Crossing Borders: Gender, Remittances and Development, Santo Domingo: UN-INSTRAW. Available from: www.un-instraw.org/View-document-details/379-Crossing-Borders-Gender-Remittances-and-Development.html.
- _____ (Denise Paiewonsky) (2007a), "El impacto de la migración en los hijos e hijas de migrantes: Consideraciones conceptuales y hallazgos parciales de los estudios de UN-

INSTRAW", Seminario Familia, niñez y migración, Quito, 26-28 February. Available from: www.un-instraw.org/es/publications/gender-remittances-and-development/3.html.

- _____ (Amaia Pérez Orozco) (2007b) "Global Care Chains", Working Paper 2, Gender, Remittances and Development Series.
- _____ (Amaia Pérez Orozco, Denise Paiewonsky, and Mar García Domínguez) (2008), Cruzando fronteras II: migración y desarrollo desde una perspectiva de género, Madrid: Instituto de la Mujer/UN-INSTRAW. Available from: www.un-instraw.org/es/publications/gender-remittances-and-development/3.html.
- _____ (Amaia Pérez Orozco and Mar García Domínguez) (2009), "El paradigma remesas para el desarrollo: evidencias empíricas y cuestionamientos desde una perspectiva de género". In Molina Bayón and San Miguel Abad (eds.), Nuevas líneas de investigación en género y desarrollo, Cuadernos Solidarios-UAM. Available from: www.uam.es/otros/uamsolidaria/investig/cuadernos_solidarios_3.pdf.
- UNRISD (ed. Shahra Razavi) (2009), The Gendered Impact of Globalisation. Towards Embedded Liberalism?, Routledge.
- UN Statistical Division (2005), Guide to Producing Statistics on Time Use: Measuring Paid and Unpaid Work, UN Department of Statistics and Social Affairs. Available from: http://unstats.un.org/unsd/publication/SeriesF/SeriesF_93E.pdf.
- Vásconez, Alison, Amparo Armas, and Jackeline Contreras (2009), Estudio del cuidado en el Ecuador, mimeo.
- Villatoro Saavedra, Pablo (2007), Las transferencias condicionadas en América Latina: luces y sombras, Presentation at the "Evolución y desafíos de los programas de transferencia condicionadas" seminar, ECLAC Brasilia, 20-21 November. Available from: www.cepal.org/dds/noticias/paginas/1/30291/CEPAL_PabloVillatoro.ppt.pdf.
- Wanderley, Fernanda (2003), Inserción laboral y trabajo no mercantil: un abordaje de género desde los hogares, PLURAL Editores, CIDES UMSA, La Paz.
- Yeates, Nicola (2005): "Global Care Chains: A Critical Introduction", Global Migration Perspectives, No. 44. Available from: www.iom.int/jahia/Jahia/policy-research/migration-policy/pid/1606.
- Zimmerman, Mary K., Jacquelyn S. Litt, and Christine E. Bose (eds.) (2006), Global Dimensions of Gender and Carework, Stanford University Press

ISBN: 978-92-1-127069-3
eISBN: 978-92-1-054576-1

# Global care chains. Toward a rights-based global care regime?

united nations instraw
Part of UN WOMEN

MINISTERIO DE ASUNTOS EXTERIORES Y DE COORDINACIÓN
SECRETARÍA DE ESTADO DE COOPERACIÓN INTERNACIONAL
DIRECCIÓN GENERAL DE PLANIFICACIÓN Y EVALUACIÓN DE POLITICA PARA EL DESARROLLO

aecid